

4.b. EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT)

In administering the EPSDT Program, the Department has established procedures to (1) inform all eligible individuals of the availability of EPSDT services; (2) provide or arrange for requested screening services; and (3) arrange for corrective treatment of health problems found as a result of screening.

EPSDT services are available through state health departments, rural health clinics, and a variety of individual practitioners both in single and group practice.

Appropriate immunizations are provided at the time of screening and as needed.

Lead screening services are provided at the time of screening or as indicated.

Screening services are available based on Georgia's periodicity schedule that was designed with recognized medical organizations involved in child health care.

Medically necessary interperiodic screens are available are necessary.

All medically necessary diagnostic and treatment services will be provided to correct and ameliorate defects and physical and mental illnesses and conditions discovered during an EPSDT screen, periodic or interperiodic, whether or not such services are covered or exceed the benefit limitations in the State Plan.

Periodic and interperiodic screenings and immunizations are covered under the EPSDT program. All other services are covered under the individual programs as described in Attachments 3.1-A, B, and E of this plan. Any limitations imposed under these individual programs do not apply to EPSDT recipients if medical necessity for the service is documented. Services which are medically necessary but which are not currently provided under the plan must be prior approved and will be reimbursed according to the reimbursement methodologies described on Supplement 1 to Attachment 4.19-B, Page 1.

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Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Continued

Catastrophic procedures, except emergency treatment.

Orthodontic treatment.

Dentures.

Management of difficult children.

Space management therapy.

Hospital time.

Preventive periodontal prophylaxis.

Pulp cap-indirect

More than two examinations/screens during office hours per recipient per calendar year.

More than two after hours emergency examinations per recipient per calendar year. Emergency treatment must receive post-treatment review.

C. PSYCHOLOGICAL SERVICES

Medically necessary Psychological services are provided to EPSDT recipients under the age of twenty-one, only upon referral from an EPSDT screening provider.

1-1-90 Services exceeding forty-one (41) hours of services per recipient per calendar year require prior approval.

Non-Covered Services

1. Services of school psychologists provided in facilities regulated by the State Board of Education.
2. Sensitivity training, encounter groups, or workshops.
3. Sexual competency training.
4. Education testing and diagnosis.
5. Marriage counseling.
6. Experimental services or procedure or those which are not recognized by the profession of the U.S. Public Health Service as universally accepted treatment.

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State/Territory: Georgia

AMOUNT, DURATION, AND SCOPE OF MEDICAL  
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

- 4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Provided:      No limitations   X   With limitations\*

- 4.b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.\*

- 4.c. Family planning services and supplies for individuals of child-bearing age.

Provided:      No limitations   X   With limitations\*

- 5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

Provided With limitations\*

- b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Provided:      No limitations   X   With limitations\*

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

- a. Podiatrists' services.

Provided:   X        With limitations

\* Description provided on attachment.

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#### 4. c. FAMILY PLANNING SERVICES

##### Limitations

Family planning clinics must meet standards set forth in the Memorandum of Agreement between the Division of Physical Health, Georgia Department of Human Resources, and Medicaid administration.

Initial and annual family planning examinations are provided to include complete patient history and pelvic examination with the following evaluative services:

Breast examination.

Hemoglobin or hematocrit.

Blood pressure.

Urinalysis for sugar and protein.

Pap smear when appropriate.

Culture for N. gonorrhea when appropriate.

Serologic test for syphilis when appropriate.

Pregnancy test if indicated.

Discussion and distribution of a contraceptive method is included.

Intrauterine device monitoring, if IUD is present.

##### Physician Office Visits

The Medicaid Program covers two office visits and 12 laboratory tests per recipient per fiscal year to a physician for pure family planning purposes. Examples of "pure" family planning procedures are IUD insertion/removal, diaphragm fitting, vasectomy, tubal ligation, birth control pills, artificial insemination and laparoscopic procedures. Additional visits may be prior authorized when medically necessary.

##### Non-Covered Services

Abortions or abortion-related services performed for family planning purposes.

Sterilization of recipients institutionalized in correction facilities, mental hospitals, or other rehabilitative facilities.

Hysterectomies performed for family planning purposes.

Indirect services to recipients such as telephone contact records and case management.

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**5a. PHYSICIAN SERVICES**

All medically necessary, recognized, non-experimental physician's services are covered when provided for EPSDT recipients under age 21.

**Limitations**

1. For recipients 21 years of age and over, Medicaid will not provide reimbursement to any physician for office visits which exceed 12 per recipient per fiscal year unless medically justified through prior authorization.
2. The Medicaid Program will not provide reimbursement to any physician for visits to a nursing home which exceed 12 per recipient per fiscal year, unless medically justified through prior authorization.
3. The Medicaid Program will not provide reimbursement to a physician for any pre-operative hospital visits to a recipient hospitalized for elective surgery, unless sufficient medical documentation is provided to substantiate such visits. Only one pre-operative hospital visit to a recipient hospitalized for non-elective surgery is reimbursable unless sufficient medical documentation is provided to substantiate additional pre-operative visits.
4. The Medicaid Program will not provide reimbursement to a physician for more than one hospital visit per patient per day of hospitalization.
5. The Medicaid Program will not provide reimbursement to non-enrolled, out-of-state physicians for "term" obstetrical deliveries on recipients who travel to other states to bear their children for reasons other than medical.
6. Reimbursement for injectable drugs is restricted to those listed in the Physician Injectable Drug List.
7. Routine refractive services and optical/prosthetic devices are reimbursable according to policies governing the Vision Care Services Program.
8. The Department has no provision for direct enrollment of or payment to auxiliary personnel employed by the physician, such as nurses, non-physician anesthetists, unlicensed surgical assistants or other aides. Physician's Assistant services are reimbursable only under criteria set forth in subsection 601.9 of the Policies & Procedures for Physician Services manual. Certified Pediatric, OB/GYN, Family Nurse Practitioners, and CRNAs are eligible for enrollment. Licensed physical, occupational, and speech pathology therapists are eligible for enrollment to provide services to recipients less than twenty-one years of age. Services provided by practitioners eligible for enrollment can not be billed by the physician. Physicians cannot be reimbursed for services provided by physician extenders except for their enrolled physician's assistants.

When the physician employs auxiliary personnel to assist in rendering services to patients and bills the charges as part of the physician's charge for the service, the Department may reimburse the physician for such services if the following criteria are met:

- a) the services are rendered in a manner consistent with the requirement of Section 901.1 of the Policies & Procedures for Physician Services manual;

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PHYSICIAN SERVICES Continued

- b) the services furnished are "incident to" services performed under the direct supervision of the physician as an adjunct to the physician's personal service;
  - c) the services are of kinds that are "commonly furnished" in the particular medical setting; and
  - d) the services are not traditionally reserved to physicians. Services traditionally reserved to physicians include but are not limited to hospital, office, home or nursing home visits; prescribing of medication; psychotherapy; and surgery.
9. Kidney transplants are covered for recipients with documented end stage renal disease. Prior approval is not required unless the procedure is performed out-of-state.

Prior Approval

The Department requires that the following services be approved prior to the delivery of such services, except in documented emergency, life threatening situations:

- 1. Tonsillectomies and/or adenoidectomies.
- 2. Removal of keloids.
- 3. Any surgery to correct morbid obesity and adjunctive surgery, i.e., lipectomies.
- 4. Plastic surgeries that are associated with functional disorders. (Cosmetic surgeries for aesthetic purposes are not covered.)
- 5. Hyperbaric oxygen pressurization.
- 6. Ligation and stripping of varicose veins of the lower limb(s).
- 7. Mammoplasties that are associated with functional disorders or post cancer surgery. (Mammoplasties for aesthetic purposes are not covered.)
- 8. More than six prescriptions per month for life-sustaining drugs for any one recipient.
- 9. More than twelve medically necessary office or nursing home visits per year (July 1 through June 30) for any one recipient.
- 10. Prior approval for liver transplantation may be requested for eligible recipients with the following disorders. Records for all candidates for coverage will be reviewed for determination of disorders, prognosis and factors of contraindication. In applying standards to provide liver transplants, similarly situated individuals will be treated alike.

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Physician Services Continued

End stage cirrhosis with liver failure due to:

Primary biliary cirrhosis;

Chronic active hepatitis (except as below);

Secondary biliary cirrhosis;

Other disorders not likely to recur in the graft and which are not associated with serious coexisting systemic disease;

Cause unknown.

Metabolic disorders involving the liver, including:

Alpha-anatitrypsin deficiency;

Protoporphyrria;

Crigler-Najjar syndrome type I;

Other metabolic disorders involving the liver for which no effective therapy exists and which are not associated with serious extrahepatic diseases.

Miscellaneous disorders including:

Extra-hepatic biliary atresia (excluding persistent viremia)

Hepatic vein thrombosis

Sclerosing cholangitis

Other disorders not listed above which are not associated with serious and irreversible extrahepatic disease, which produce life-threatening illness, for which no other effective therapy exists, and for which transplantation would be beneficial.

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Physician Services (Continued)

Non-Covered Services

1. Cosmetic Surgery.
2. Services provided by a portable x-ray service.
3. Laboratory services furnished by the State or a public laboratory.
4. Experimental services, drugs or procedures are those which are not generally recognized by the medical profession or the U.S. Public Health Service as acceptable treatment.
5. Non-essential foot care for recipients twenty-one years of age or older, including elective procedures such as, but not limited to, hammertoe repair, bunionectomies and related services and treatment of ingrown nails.

6.a. PODIATRY SERVICES

Limitations:

1. The Medicaid program will not provide reimbursement to any podiatrist for office visits which exceed 12 per recipient per fiscal year except in the case of EPSDT eligible recipients for whom medical necessity for additional services must be documented and provided to the Department.
2. The Medicaid program will not provide reimbursement to a podiatrist for nail debridement on patients who are not diabetic or do not have peripheral vascular disease.
3. The Medicaid program will not provide reimbursement to a podiatrist for more than one inpatient hospital visit per recipient per day of hospitalization.
4. The Medicaid program will not provide reimbursement to a podiatrist for services rendered in a nursing home unless referral is made by the patient's attending physician.
5. Reimbursement for injectable drugs is restricted to those listed in the Physicians' Injectable Drug List.

Prior Approval

All surgery performed in a nursing home by a podiatrist must be approved by the Department prior to the surgery, except the following:

1. Routine debridement of mycotic nails.
2. Incision and drainage of abscess with documented cellulitis.

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Podiatry Services (Continued)

Prior Approval (Continued)

3. Surgical debridement of stasis, performing, or decubitis ulcer.
4. Emergency relief of pain and infection except that all procedures involving soft tissue or bone surgery must be prior approved by the Department.

Prior approval is required for the surgical correction of flat feet.

Non-Covered Services

1. Ancillary services unrelated to the diagnosis or treatment of the patient.
2. Services provided by a portable x-ray service.
3. Services performed outside the scope of the practice of Podiatry as outlined in the applicable State law.
4. Experimental services or procedures or those which are not recognized by the profession or the U.S. Public Health Service as universally accepted treatment.
5. Charges for the following services:
  - a. Flatfoot - The evaluation or non-surgical treatment of a flatfoot condition regardless of the underlying pathology.
  - b. Subluxation - The evaluation of subluxation of the foot and non-surgical measures to correct the condition or to alleviate symptoms.
  - c. Routine Foot Care - Routine foot care for ambulatory or bedridden patients: includes cutting or removal of corns, warts, or callouses; the trimming of nails and other hygienic and preventive maintenance care in the realm of self-care such as cleansing, soaking, and the use of skin creams.
  - d. Supportive Devices - Orthopedic shoes rather than shoes that are an integral part of a brace and arch support. An orthopedic shoe that is built into a leg brace is reimbursable. Biomechanical orthotics are not reimbursable.
  - e. Vitamin B-12 Injection - To strengthen tendons, ligaments, etc., of the foot.
6. Non-essential foot care for recipients twenty-one years of age or older including elective procedures such as, but not limited to, hammertoe repair, bunionectomies and related services, and treatment of ingrown nails.

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